# the psychiatric bulletin

FOR THE PHYSICIAN IN GENERAL PRACTICE

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PHOBIAS — Page 36

THE
# PSYCHIATRIC
BULLETIN



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THE COVER

Fear of mice is one of the most thoroughly investigated of the animal phobias. This phobia has been variously explained; and explanation commonly found in psychiatric treatment suggests that the frightened woman conceives of the mouse as a phallic symbol. Equating the mouse with the penis, she unconsciously visualizes the creature as entering her vagina, gnawing and destroying her body.

The painting on the cover was executed by Mr. Joseph F. Schwarting.

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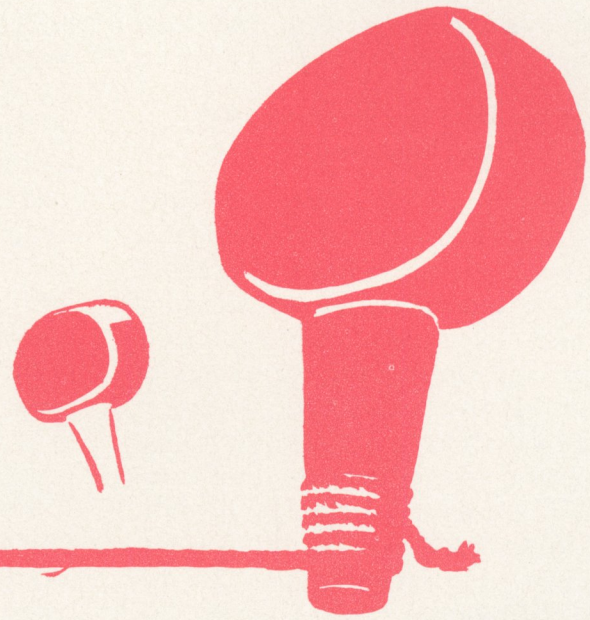
# THE PSYCHIATRIC BULLETIN

## Contents


ILLNESS AS A
SCHWARTING

# REACTION TO *Stress*



MORE AND MORE PHYSICIANS are finding it useful to think of illness in terms of total adaption to life stress. This viewpoint starts with the basic postulate that attempts of the individual to adjust to his environment are associated with changes in bodily function. These physiological changes, if prolonged, sometimes lead to actual structural damage. If man is to maintain a state of well-being, not only must his physiological processes remain in fair balance—the entire scope of his contact with the environment must also be stabilized within reasonable limits.

The concept of homeostasis, originally applied by Walter Cannon to the maintenance of constancy in the bodily fluids, has thus become broadened. Homeostasis is still used to describe the balance in respiration, digestion, and maintenance of the blood glucose and hormonal levels. But it may also be regarded from the standpoint of the total organism. Therefore, the patient's behavior, interpersonal relationships, and role in society assume due importance to the physician, along with the automatic and semi-automatic responses elicited by the sympathetic nervous system.

### *What is a "stress reaction?"*

Whenever the normal equilibrium of the body is severely disrupted, stress in some form can be said to be the cause. The stress may be physical trauma, or it may be an infectious organism, or it may be a state of emotional tension. Physicians no longer seek to ascribe a single etiological factor to all forms of illness. Instead, they look for an overall group of stress-producing factors. As a result, illness becomes more amenable to therapy.

Many of the old and familiar diseases may be thought of as reactions to stress. It is quite feasible, for example, to consider the infectious diseases from this standpoint. One may suppose that the human organism is invaded by the flu virus. A chain of reactions results. Among these are such changes as local inflammation in the respiratory passages, a rise in body temperature, increased leucocyte count, and the formation of antibodies in the blood. But can this be said to be the *total reaction* of the patient? The human organism, and reputedly some subhuman species, will experience a reaction which goes beyond the automatic. He will *do something* calculated to make him well. He will seek out some substance with medicinal properties, or he will betake himself to some individual whom he believes can afford him some relief. If the combination of these measures proves successful, the patient recovers, and it may be said that he had adapted satisfactorily to the stressful situation initiated by the virus.

When the individual is faced with an emotionally stressful situation, a series of adaptive measures also occurs. These have both physical and nonphysical components. The physical components are widely recognized. Various people react to emotional tension with similar physical signs, such as rise in blood pressure, quickened pulse, increased cardiac output and alteration of the respiratory and gastrointestinal functions. Any experience which the individual recognizes as threatening is apt to provoke these physical manifestations. They constitute a normal response to a condition which is potentially "abnormal," i.e. dangerous.

The concept of the stress disorders proceeds one step further. It implies that when an individual remains in a state of *chronic stress*, the normal physical reactions become overworked and the corresponding body systems, overtaxed. For physiological processes, once initiated, may fail to subside when the stress is alleviated. Those organs which are weakest, and those having the highest susceptibility to disease are generally the first to reveal impaired function. Selye has termed this "increased physiologic responsiveness in the related physiologic system." This type of illness has been termed "psychosomatic disorder," "somatization reaction," "psychophysiological reaction," "stress disease," and "disorder of adaptation." Any of the terms are appropriate, although the

latest Standard Nomenclature eliminates the term "psychosomatic" because of the implication that bodily changes are *the result of* emotion. It is probably more accurate to state that mood changes and bodily changes are *both part of the total reaction* to stress.

### *What illnesses make up the "stress reactions?"*

A review of the common categories of illness seen by the internist and the physician in general practice reveal an extensive list of ailments in which life stress clearly plays a role in augmenting the symptoms of disease. Disturbances in gastrointestinal functions are so closely allied to stressful life situations that a review of emotional patterns is indicated in the evaluation of the patient. Cardiovascular irregularities accompany situational disturbances so often that life conditions are among the first factors to investigate in cardiac patients. Impotence and frigidity, as well as menstrual dysfunction, dispanuria, and pruritus vulvae, are known to follow instances of environmental stress. Asthma, headache and many skin disorders also prevail in conditions of life stress, indicating the common susceptibility of the whole gamut of body systems. Indeed, so many different medical problems are included in the disorders of adaptation that the psychosocial environment assumes importance in the understanding of almost all illness.

### *How does stress work to produce illness?*

The *extent* to which exposure to life stress contributes to illness has long been a matter of conjecture. In an effort to clarify this relationship, an epidemiological survey was undertaken by Dr. Lawrence E. Hinkle, Jr., of Cornell, among a fairly homogeneous segment of the general population. The results should interest any physician who thinks of his patient as something more than just an aggregate of body systems.

In planning the survey, it was first determined that certain conditions would have to be fulfilled in order to assure meaningful statistics. First, the group would have to be drawn from an essentially well population; thus, hospital patients were automatically excluded. Second, it would have to be a group in which prolonged observation was possible and medical records were available. Third, living conditions would have to be fairly equitable among the members of the group, leaving as the major large variable the degree of stress encountered by the different individuals. It was felt that these requirements would be best answered by selecting employees who all held the same type of job in the same location. A group which apparently met these specifications was found within the telephone company of a large metropolis, where records on over 1300 female telephone operators were available for study.

Preliminary examination of attendance records soon revealed that sickness disability was not distributed evenly throughout the group. Nor was it a random factor. Instead, it fell into a repetitive pattern. Within the span of one year alone, roughly three quarters of the absences were attributable to but one quarter of the women. Since the record for one year could not be considered a decisive sampling, 20 women from the highest absence group and 20 from the lowest were selected for intensive examination. Medical records on all these women extended back for 20 years. Analysis of the records uncovered facts which had not been anticipated by the employing organization. The analysis showed:

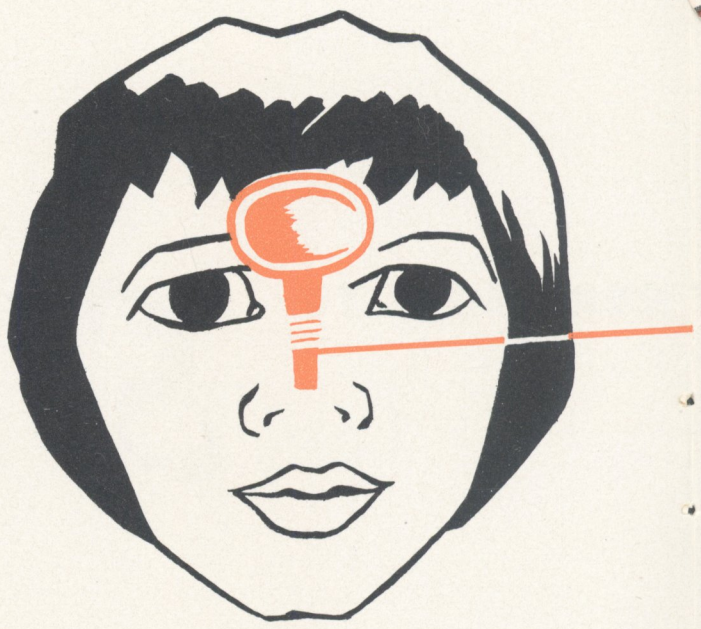
1. Year after year, certain individuals became ill *more frequently* than others.

2. These same individuals suffered *more varieties of illness* than did the others.

3. The same group had *more disabling accidents* than the other employees.

Interviews were then conducted in an effort to determine what life stresses might be rampant in this group, and to compare this with the conditions found in other groups.

No appreciable difference was found in the heredity or family histories of the two categories of women. Economic background was fairly constant throughout both groups. Opportunities for exposure to infection were not noticeably higher



in the "ill group." The only factor in which a conspicuous difference appeared was the prevalence of emotional stress. The group of well women all expressed themselves as being generally satisfied with their lives as they found them. The ill women, on the other hand, remained in a state of chronic emotional tension as a result of discontentment with their respective life situations. Referring to women in the "ill group" investigator Hinkle said, "they had spent their adult lives in situations of insecurity and frustration, working at a job which they disliked, having little recreation, little security, little satisfaction in life." The well women, however, had no unwanted family responsibilities, and spent their lives contentedly in an occupation of their own choosing. The woman's individual needs, as determined by her early conditioning, and the way in which these needs were answered, appeared to be the most important factor in determining a chronically stressful situation.

### *Diagnosis of stress disorders*

In dealing with stress disorders, diagnosis of the patient's condition embraces both physical and psychological manifestations, although both components are part of the total reaction. The search for organic damage proceeds through usual diagnostic measures. Most likely, the patient will show a combination of physical and psychiatric symptoms which, taken together, add up to a multiple diagnosis. Usually, the more pressing physical disturbances will

receive first consideration, since they are ordinarily cited as the presenting complaint.

It is more difficult for the general physician to evaluate psychological maladjustment, because the symptoms are often nebulous and transitory. The patients themselves may not be immediately helpful in uncovering sources of stress. Usually. they are unaccustomed to having to correlate the appearance of symptoms with events in their daily lives. In many cases, they may not recall any stressful event, or they may have even repressed the knowledge that stress existed. Indeed, the distinguishing characteristic of neurotic reactions is that the anxiety underlying the formation of symptoms is largely unconscious.

Psychiatric diagnoses, of course, are made by examining the patient and studying his history. While assembling the history the physician gets his first indication of possible sources of stress. For the manner in which the patient expresses himself and the points at which he displays emotion convey important information to the alert observer. When the voice falters, eyes fill with tears, hands become fidgety, or the chain of thinking becomes blocked, the physician will recognize that a touchy subject is being approached. As Dr. Hinkle observes, "one quickly learns to recognize and evaluate sensitive topics by their symptoms and signs, and to investigate them cautiously, with due respect for their tenderness, much as one would palpate a furuncle."

Often the physician can help the patient discover the source of his stress. The physician may inquire, for instance, "During previous sieges of illness, were there any disturbing factors present in your home life, or in your work?" Sometimes such an inquiry will lead to the patient's first realization of the nature of a basically stressful condition in his life.

In recording the diagnosis, it is helpful to indicate what is producing stress upon the patient, as well as an estimation of his capacities for resisting it. This may prove useful in establishing a prognosis and determining the patient's possible susceptibility to further illness.

### *Therapy in stress disorders*

Therapeutic measures of several types may be required for patients with stress disorders. After appropriate medical and surgical therapies are applied, there may be some residual psychological disturbance. If this is not recognized and alleviated, new psychophysiological symptoms may appear at any point in the body. Therefore, it is important to deal with the emotional factors.

Some physicians believe that the more closely an episode of illness is related to a situation of stress, the closer the trouble is to the surface and the easier it is to rout. Severe psychological disturbances are harder to connect with stressful stimuli than are the minimal, transient ones. In a patient with a previously well-integrated personality, i.e., one whose life adjustment has been generally satisfactory, psychotherapy of a superficial type should be adequate. This consists of such measures as emotional catharsis, or letting the patient "talk it out," explanation and reassurance, and manipulation of the environment. Although this is termed "superficial psychotherapy," it is superficial only by contrast to the uncovering of unconscious conflicts which are deeply pathological.

The physician's general attitude is highly significant in psychotherapy. In order to get a more meaningful history, the physician shows that he is interested in the patient personally, takes time to hear him out, and accepts uncritically whatever he has to say. Often feelings of self-blame are present, and one of the strongest therapeutic factors at work on the patient is his discovery that his physician accepts him without condemnation or surprise. Thus, feelings which have been too painful for the patient to face become mitigated, and are divested of much of their ability to produce psychic pain.

The physician can explain that with the passage of time, individuals develop characteristic patterns of dealing with painful feelings, and these can prove costly by taking a toll on their health. The explanation need not be involved; in fact, the simpler and more casual it is, the more reassurance it carries. Reassurance is furthered by some additional physical tests, although it is wise for the physician to tell the patient that he expects these to be negative. This will preclude a suspicion by the patient that the diagnosis is incomplete. Manipulation of the environment is often possible after the physician points out that if the stressful situation persists, the patient must expect to pay for it in terms of his comfort and possibly his health. When he views the situation from this perspective, the patient may be stimulated to make some indicated changes for which he had not seen the necessity before. The experience of facing and thrashing out a disturbing situation with his physician aids the patient by strengthening his resources for meeting further stress. Accomplishing this may take a little more time, particularly in the initial interviews, but the time required cannot be said to be wasted. The time spent is more invested, since it establishes a worthwhile basis of lasting confidence. For the physician who knows his patients well has a valuable therapeutic tool and a better opportunity than anyone else to make his therapy effective and continuous.

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# THE

SINCE a number of physicians in general practice have expressed an interest in some reliable method for supplementing their medical records with significant psychiatric material, the following suggestions have been compiled for the readers of The Psychiatric Bulletin. Psychiatrists are frequently asked, "how long does it take you to perform a psychiatric examination?" Dr. Abe Hauser, speaking before the Texas Neuropsychiatric Association in Houston in 1953, stated that recording of the history should take at least an hour, in many instances requiring several interviews. The points to be examined are manifold and embrace subtleties not necessarily considered in the routine medical history.

The psychiatric evaluation is concerned with the total person. It seeks to determine the way the patient thinks, acts and feels. It begins with history-taking.

The first item to record in the history is, of course, the presenting complaint. Whitehorn, of the Henry Phipps Psychiatric Clinic, notes that it is frequently illuminating to initiate the interview with a spontaneous discussion of the chief complaint. This establishes rapport and gives the patient the feeling that the physician is seriously concerned with his welfare down to the last detail. The consolation to be derived from this thought also marks the beginning of psychotherapy. Though it may slow down the accumulation of facts to allow the patient to lurch into seemingly irrelevant talk, this can be extremely revealing in terms of the personality study. For talk which on the surface appears irrelevant may have for the patient a definite aim, such as self-justification. Thus, seemingly inconsequential prattle should be examined from the perspective of why the patient needs to do it. In conducting the interview, the examiner will find that the more he is able to "feel with" the patient —an attribute referred to in psychiatry as "empathy"—the more accurately will he comprehend what the patient means by his responses. A physician who has this nebulous but important attribute will find that he sometimes can sense when a patient gives misleading or downright false information. As therapy progresses, he may also be able to understand *why* the patient chose to be misleading in his remarks. Patients often give responses which they consider in keeping with cultural and social demands, rather than expose their true feelings. For example, on the initial interview the patient may give a picture of warmth and affection between himself and his parents and, only much later, when he comes to feel more trust in the physician, will he reveal his conscious feelings of hatred toward them. The physician therefore, takes the initial interview with reservation, particularly in those areas in which everything is represented as "just dandy."

During the discussion of the presenting complaint, it may prove extremely rewarding to attempt to fit the illness into its appropriate relationship with the patient's life situation. Two questions are significant in this attempt. "What circumstances may have helped to precipitate the illness?" "What factors seem to make it worse?"

Another important consideration in the psychiatric evaluation is the patient's attitude toward his symptoms. Do they embarrass or infuriate him? Does he deny or welcome them? Such attitudes are often apparent from the patient's manner of describing his illness. Merely asking

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the patient how his symptoms have affected his life can produce evidence of emotional involvement which is helping to keep him ill.

Direct observation of the patient as he tells his story also offers clues to his mental attitude, since anxiety is often displayed physiologically. Signs to watch for include excessive perspiration, tense postures, restlessness, distractability, or strained vocal tones.

Through these informal methods, the physician can obtain a fair idea of the type of person he is dealing with and, at the same time, he puts the patient at his ease. Then it is possible to proceed with routine questioning in an atmosphere of mutual confidence. The list of questions selected is not nearly so important as the maintenance of a flexible attitude toward the information derived from them. The physician who understands how anxiety operates in producing and perpetuating illness, remains on the alert for evidence of anxiety during all portions of the interview.

Many excellent outlines have been prepared for the physician's use in eliciting the details of a patient's history. Masserman presents a list of topics used as reminders in compiling a history which takes into consideration personality factors and the patient's characteristic methods of adaptation.

### *Family background*

Any information which can be obtained about significant traits in parents and siblings of the patient should be recorded. This is important because the personality of every individual is influenced by early family relationships. Not only the genetic endowment, but also the early home environment, establishes reaction patterns to be used throughout life. This part of the history does much to explain the presence of undue aggressiveness, oversubmissiveness, resistance to authority, or other traits found in the adult.

### *Early development*

Whatever the physician can learn of his patient's early childhood may prove of value. Illness, traumatic experiences or any deviations from the expected in his development are important. Delay in walking or talking, feeding difficulties, enuresis or temper tantrums may have caused his parents some concern. These are fairly common manifestations in childhood, yet they are sufficiently deviated from the normal as to suggest early emotional conflict. Manifestations such as these may signify a silent protest by the child to some emotionally disturbing situation.

### *Schooling and initial socialization*

After the home relationships are noted, the patient's early social adjustment becomes an appropriate item for study. This embraces the individual's scholastic status, his athletic and extracurricular pursuits, and his ability to get along with playmates and instructors. Any conspicuous honors are worth mentioning as well as any unusual difficulties encountered by the patient.

### *Sexual development and attitudes*

The formation of sexual attitudes is significant, particularly if these ideas are associated with feelings of fear and guilt. The groundwork for these attitudes is laid in the individual's association with his parents, many instances of sexual maladjustment in adult life being traceable to parental handling of the child's sexual curiosity and experimentation. The love relationship between the

parents themselves further contributes, in subtle but lasting ways, to the sexual attitudes which characterize their offspring throughout life.

### *Habit development*

Inquiry may be made into the patient's eating and sleeping habits, and use of any products which may constitute an overindulgence. Tobacco, alcohol and drugs are among the first which come to mind, but habitual dependence on stimulants or sedatives is even more important in uncovering tendencies to fall back on artificial defenses.

### *General social adjustment*

The patient's choice of friendships, hobbies and recreational pursuits may be of interest, together with a record of his participation in group activities and civic work. The significance which these factors have to the patient may shed light on his evaluation of himself, whether he feels that he "belongs" or is an outsider in the game of life.

### *Occupational history*

Adjustment to the demands of an occupation presents a challenge to persons of all types, and early failures are liable to appear in the vocational history of less stable individuals. Indeed, failure to sustain employment for long periods of time and frequent change from one field of endeavor to another is strong indication of a conflicted individual. The type of work selected may be dictated by some pressing inner need. A history of repeated difficulty with employers suggests a residue of unresolved conflict relating to parental authority. The patient's attitude toward his fellow workers may be revealing, as well as his capacity for cooperation or his feeling of competition.

### *Military history*

Reactions invoked by military discipline and the possibility of combat may be elicited with beneficial results. Resentments which exceed the traditional Army "gripes" should be examined carefully, as well as the development of overdependency, as seen in apparent relief that others have to make decisions and do the thinking for him.

### *Effects of injuries and illness*

Previous organic illnesses and the patient's reaction to them, whether he shows an "aptitude for invalidism," is accident-prone, or overly dependent on medical care, are significant.

### *Transition to present illness*

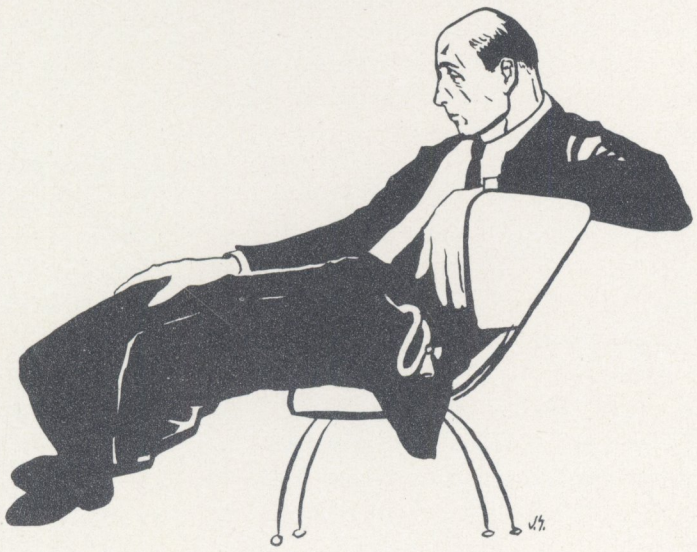
Circumstances leading up to the present condition of the patient, and his reasons for seeking medical aid will round out the interview and perhaps render more significant the information already gleaned with regard to the presenting complaint.

While in the process of obtaining the patient's history, the physician has an opportunity to make several additional observations of his own. These are quite important in the evaluation of the mental status. Observation by a trained observer is sufficient to establish many instances of strongly unhealthy mental content. Hypochondriasis becomes evident upon inquiry into the status of the various organ systems, if this attitude has not intruded itself before. Special preoccupations, phobias and obsessions should be noted whenever they appear. Distortions in thinking, such as paranoid delusions, may be harder to discover, unless the interview is so comprehensive that it happens to touch upon the particular subject embraced by the delusion.

Some people are obviously mood-dominated. It is important to record whether the prevailing mood is one of anxiety, hostility, suspicion, depression or well-being. The intensity and appropriateness of emotional responses are important in the diagnosis of early schizophrenia and other disorders. In some depressed patients, the degree of apathy prevents the assembling of any reliable historical facts. Such a condition must not be overlooked in recording the psychiatric history.

In addition to the data gained from interview and personal observation, the physician may further his understanding of the patient while conducting some simple neurological tests. When the sensorium shows impairment, rendering the patient disoriented for time and place, the physician naturally thinks of organic brain damage and looks for neurological signs. In the absence of such symptoms, examination of this nature is not so often employed. Yet, even in the absence of any suspicion of damage to the central nervous system, the physician is justified in checking reflexes, muscular coordination and motor response. These measures reassure the patient and provide time for friendly, off-the-record conversation. This gives the physician an additional opportunity to observe the patient's overall bearing, his mannerisms and general outlook undistorted by self-consciousness. For when the patient knows that his body is under scrutiny, his mind will very likely be off guard.

Whether the purpose of the interview is to supplement the medical record or to obtain a more extensive psychiatric evaluation, a workable formulation can usually be made if the above factors are considered in a sincere and comprehensive examination.

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Whitehorn, J. C.: Guide to Interviewing and Clinical Personality Study, Arch. Neurol. and Psychiat. 52:197 (Sept.) 1944.

# RAY

DURING the Nineteenth Century, psychiatry in America was concerned more with social reform than with new discoveries about the workings of the mind. Among the reforms instituted during this period were better facilities for the care of mental patients and improvement in the legal status of those who were judged insane. Both of these reforms were memorably advanced by the work of Isaac Ray.

Throughout the span of Ray's lifetime, 1807-1881, psychiatry was heavily influenced by the humanitarian efforts of his predecessors. In America, Dorothea Dix had opened the way for more and better mental institutions; in France, Pinel had revolutionized the care of the insane by demonstrating the effectiveness of kinder treatment measures; and in England, the illustrious Tuke family had worked diligently to remove the stigma of mental illness from the public mind. Following his graduation from Harvard Medical School, Ray traveled abroad, studying the conditions affecting the mentally ill in various countries. Upon his return to America, he began practicing medicine in Portland, Maine, following which he was appointed superintendent of the mental hospital in Augusta, Maine. Shortly thereafter, in 1847, he assumed charge of Butler Hospital in Providence, Rhode Island —a position which he held for twenty years.

As a hospital superintendent, Ray gave particular attention to the factors responsible for the attitude of

public dread toward mental institutions. He set about to correct the barren atmosphere, the bleak and monotonous interiors, the overcrowding of patients, and supervision by inadequately trained employees. Although a popular trend of the times was toward the abolition of all mechanical restraints on asylum patients, Ray felt that this was unwise. He contended that restraint was necessary for a small per cent of the patients, describing it as "a necessary evil, used only for the prevention of a greater."

In 1844, thirteen superintendents of mental hospitals banded together to form an organization which later became the American Psychiatric Association. Ray was one of the founders. The perspective of a century has shown that Ray's preliminary work in medical jurisprudence provided a sound basis for the reforms implemented by the Association for decades to come.

Ray felt that injustices toward the mentally ill prevailed as a result of lack of clarification of their legal status. In both criminal and civil law, he felt that mental patients often failed to receive fair treatment. He cited the fallacies inherent in using the McNaughten Rule as the sole criterion for establishing culpability in criminal cases. He felt that the problem of criminal responsibility was over-simplified unduly by merely inquiring, "did the defendant know what he was doing and did he know that it was *wrong?*" It was obvious to Ray, as it is to any physician who has had experience with psychotics, that a man may be quite demented and still be capable of recognizing the difference between right and wrong. Ray was not a sentimentalist who contended that all criminals were mentally ill. But he did feel that the small percentage who were insane were judged by legal standards decades behind the state of psychiatric knowledge.

He pointed out that in the courts of law, the mind was conceived from its purely intellectual aspect. Neither lawyers nor jurists were accustomed to thinking in terms of emotional, sociological or biological factors, which also affect the behavior of an individual. Ray devoted much effort in behalf of those patients afflicted with "moral insanity," which meant that they could be intellectually sound, yet incapable of resisting some impulsive criminal act. This concept is of major significance in psychiatry—it provided a forerunner for that group of character disorders classed as psychopathic, or sociopathic personality. Ray held that this type of criminal, "whose reason shares a divided empire" with his emotions, should not be permitted to go free. Still, he did not feel that they should be classed as hardened criminals, but preferably should be confined for treatment in the hope of an eventual cure.

Ray observed the fallacy inherent in the blunt assumption that every individual is either sane or insane. He wrote, "Jurists, who have been so anxious to obtain some definition of insanity, which shall embrace every possible cause, should understand that such a wish is chimerical, from the very nature of things." He took the position "let the prosecution try to prove the defendant sane, rather than ask the defense to prove him insane," and they will see what they are up against.

Ray's prolific contributions to the literature of mental disorder have been hailed for a century for their progressiveness and clarity. His "Treatise on the Medical Jurisprudence of Insanity," published in 1838, went through six editions, and was acclaimed the first and the most important work on this subject in the English language. Emphasizing the need for members of the legal profession to reconcile their procedures with medical findings, this volume was a tremendous influence in shaping court decisions in regard to the mentally ill.

In 1850, Ray presented his "Project of a Law," which proposed a code of civil rights for mental patients deprived of their liberty. The legal status of such patients was inconsistent throughout the different states, and their confinement was not regulated by statute. Ray pointed out that this condition led to all manner of corruption and was "fruitful of evil to all parties concerned." Ray's 21 provisions were studied for five years by the Association of Medical Superintendents and finally adopted as a criterion for the desirable legal attitude toward mental patients. The Association then devoted concerted pressure toward having the statutes amended in accordance with Ray's humanitarian views.

Even though many laws were eventually changed, the process was halting and fraught with dissension in many states. Throughout the country, however, there was a gradual awakening to the fact that the insane also are entitled to "certain inalienable rights." The goal was stated eloquently by Ray, "we must look for improvement, not so much to any devices of legislation as to broader views and a firmer spirit on the part of those who administer the laws, to a higher sense of professional honor, both in the lawyer and in the physician, and to a healthier public sentiment."

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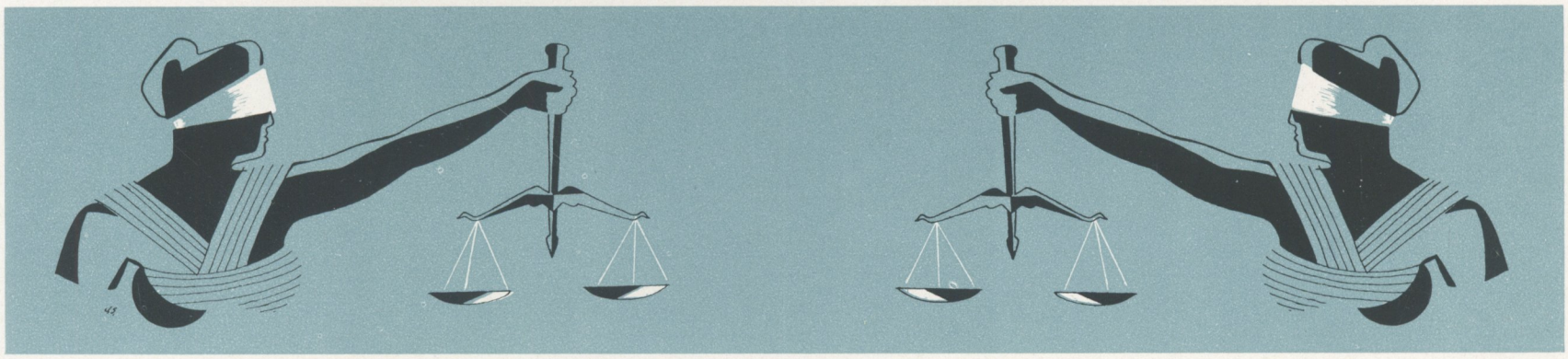


# Questions and Answers

**QUESTION:** Are there any recent studies which correlate cerebral insult with emotional stress?

**ANSWER:** Dr. Arthur Ecker has published a preliminary report of 20 cases which correlate cerebral insult with specific emotional stress. Emotional stress is not presented as *the* precipitating factor but rather as a possible contributing one. Cases outlined include both nontraumatic intracranial hemorrhage and sudden hemiparesis. The reader is impressed with the youth of some of the patients in this series. While physicians have long recognized the close association between emotional and vascular states, few have emphasized the immediate precipitating circumstances when strokes occur among younger persons.

A 17-year-old boy, of a retiring and somewhat effeminate nature, was the son of a man who prided himself on his vigor and athletic prowess, who did not conceal his intolerant feelings toward the boy. Upon beginning to work with his father, the youth suffered severe headache, right hemiparesis and aphasia. Neurologic examination and pneumoencephalogram were normal. Temporary blockage of the internal carotid artery, as revealed by angiography, was attributed to spasm of the artery. The spasm was substantiated when later arteriograms showed normal filling of intracranial arteries. Following his improvement, psychiatric interviews were begun. During an interview while his father was present, the boy reacted with a brief recurrence of the aphasia. This case history illustrates hemiparesis without any evidence of arterial thrombosis.

In an 11-year-old girl, anticipated desertion fears were apparently reactivated and precipitated a hemorrhage into the basal ganglia. The child failed to find her mother at home one day as expected, ran through the neighborhood trying to find her, and finally collapsed. Examination revealed bloody spinal fluid and left hemiplegia; angiography was inadequate; pneumoencephalography revealed enlargement of the right basal ganglia and hydrocephalus. One month later, the test revealed atrophy of the right thalamus and parieto-occipital region of the right cerebral hemisphere.

A 25-year-old man was being studied by a urologist. On the date scheduled for his third visit, the patient experienced sudden onset of extreme anxiety and severe headache. The headache continued for five months, gradually increasing in severity. In addition, he developed transitory anomia, alexia, unsteady gait, and intermittent fever. Examination and craniotomy revealed left occipitotemporal intracerebral hematoma. Six months after surgery, the patient confided to his physician that he had been consulting the urologist to determine possible sterility. On his first two visits, he had been unable to produce semen. The possibility of failure on the third visit represented the greatest personal threat he had experienced in his life and initiated the onset of symptoms which led ultimately to surgery.

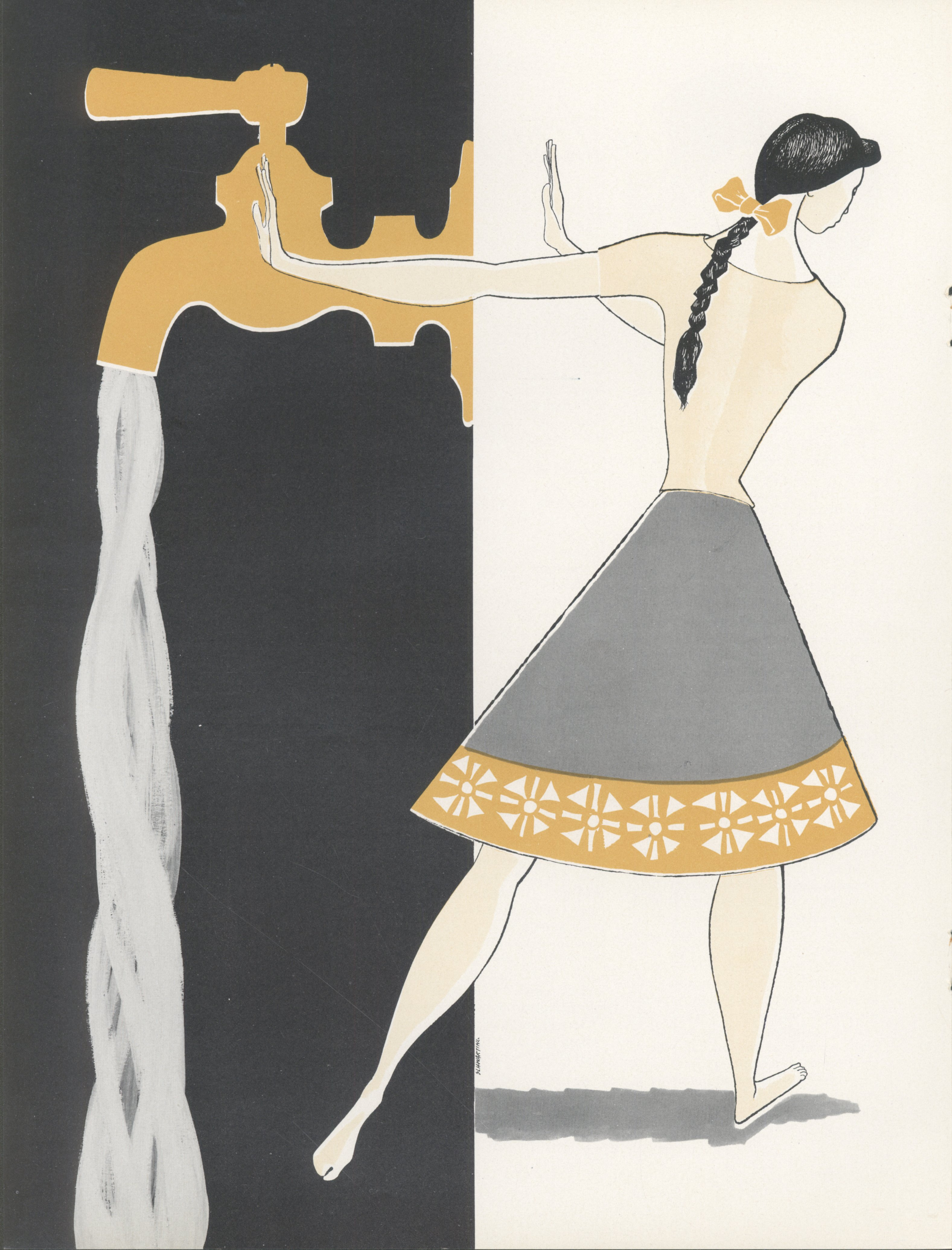
The investigator summarized by calling attention to the "special emotional stress which immediately preceded the stroke" in 15 of the 20 cases. In addition, 13 of the 20 cases exhibited long-standing personality difficulties prior to the stroke. Ecker concluded that in such patients the threshold for the production of arterial spasm is lower than average.

Reference: Ecker, A.: Emotional Stress before Strokes: A Preliminary Report of 20 Cases, Ann. Internal Med. 40:49 (Jan.) 1954.

**QUESTION:** What type of occupational therapy is most beneficial for men whose convalescence is prolonged?

**ANSWER:** When men must be incapacitated for long periods of time, it is of extreme psychological value to engage them in activities with masculine significance, whenever possible. This not only provides a feeling of satisfaction, but is also useful in forestalling the appearance of helpless and dependent attitudes in the patient. Maximum benefits from occupational therapy are not attained when men are assigned such activities as knitting, or sewing. Fly-tying is extensively used and is sports-oriented. Antique guns in bad condition can be purchased reasonably and these can be repaired and polished. Bamboo poles are inexpensive and can be made into magnificent flyrods. The carving of hunting bows calls for precision and constitutes a true art of handicraft. Stringing tennis rackets and covering baseballs have also been suggested. Lens kits may be purchased as war surplus and the patient taught to build simple telescopes and field glasses. Unconsciously, male patients derive emotional strength from working with objects which increase their masculine self-respect and salvage them from boredom, while creating something they feel is worthwhile.

Reference: LeShan, L., and LeShan, E.: The Psychodynamics of the Male Patient, Am. J. Occupational Therapy 6:208 (Sept.-Oct.) 1952.



EVERY PRACTITIONER discovers early in his clinical work that the textbook disease entities learned in medical school bear scant resemblance to the sick people he is called upon to diagnose and treat. This is particularly true of the neuroses. If it served no purpose other than to enable the physician to put a label on the patient, the learning of the various neurotic syndromes would be of questionable value. Hardly anyone ever sees a "pure" case of hysteria, obsessive-compulsive reaction, or phobic state. A more useful perspective might be to consider the various neurotic syndromes as representing different patterns of reaction to emotional stress, i.e., different mechanisms available to the individual in attempting to deal with his problems. Then a diagnosis may be made according to the *predominant* mechanisms employed by the patient, without having to consider additional symptoms that will not fit into the textbook picture.

A phobia can be defined as a persistent, unreasoning fear of something (object, situation, person, animal, etc.,) that appears objectively groundless or grossly exaggerated in degree. When these morbid fears are the predominant symptoms shown by the patient, a diagnosis of phobic reaction would be made. The essential mechanism in the development of a phobia is this: anxiety generated by some emotional conflict is *displaced* from its original source to some external object or situation. This displacement is never arbitrary and meaningless; there is always some associative, or symbolic, link between the original anxiety-provoking conflict and the feared object. A classical case history, first cited by Freud, will illustrate:

A young girl had for many years a morbid fear of running water. Even running water from a hydrant would provoke an almost unbearable anxiety. She was completely at a loss to explain this fear until she was visited by an aunt whom she had not seen since childhood. Shortly after arriving the aunt took her aside and whispered "I've never told our secret." Upon hearing this, the patient suddenly remembered an incident that had occurred when she was five years old. Against her mother's strict orders she had slipped away to go wading in a stream with a small waterfall. While wading, she lost her footing and was drawn under the waterfall by the current. The aunt happened along and rescued her, then helped her dry out her clothes and agreed to keep the secret so the little girl would not be punished by her mother. With the recovery of this memory, the woman lost her fear of running water. In this case the running water was a sort of abbreviated mental symbol for the original anxiety-provoking scene, the rest of which had been blotted from conscious memory. The emotional response was appropriate enough in the original setting—terror at the near-drowning and fear of the mother's punishment. Whenever the *full significance* (conscious and unconscious) of a phobia is understood, the emotional response of the patient no longer seems inappropriate or unintelligible. One might wish that all phobias were as simple in origin and as dramatic in recovery as the above case apparently was, but this is rarely so.

### *Types of phobias*

After the introduction of the general term *phobia*, a rash of words were coined to indicate specific fears, e.g., aleurophobia—fear of cats, acrophobia—fear of high places, even phobophobia—a fear of fear. A long list of these terms may be found, with definitions, in any standard medical dictionary. Nothing useful is gained, however, by translating the English words into their Greek equivalents. There is practically nothing one can say in *general terms* about the meaning of any *specific fear*. Its only real significance lies in its completely private and individual meaning to the particular patient. What is more important, it would do no good and probably do harm if the physician were to immediately tell the patient what his phobia symbolized. While it is true that certain specific phobias are *almost constantly* associated with emotional conflicts of a predictable nature, the therapist must in each case guide his patient to make the discoveries for himself.

### *Dynamics*

As in all neurotic symptoms, the phobia serves the patient a positive, useful purpose—despite its painful, unpleasant, sometime incapacitating nature. For this reason alone he will be loath to give it up until some better solution to his conflicts is in sight. The whole process usually starts off in some situation where forbidden impulses—usually of a sexual or a hostile nature — are aroused. It is the fear of these impulses, or dread of the anticipated punishment for their expression, that generates the initial anxiety.

# PHOBIAS

In an attempt to ward off these impulses, to prevent their breaking through into consciousness, the patient unconsciously displaces the anxiety to some outside object or situation. This not only diverts the attention and interest away from the forbidden impulses but also converts the anxiety into something more *manageable* by relating it to an external stimulus that can be at least partially avoided.

Sometimes the situation is different in that something originally *wished for* unconsciously becomes *feared* instead, with no displacement. The familiar old maid's fear of the man under her bed is a good example of this mechanism.

If the initial solution of the conflict were completely successful, few phobic patients would ever come for medical treatment. That is, if the forbidden impulses were forever barred from attempting to enter consciousness and only a fear of some *one* avoidable situation remained, the patient could get along fairly comfortably. The trouble is that there is usually a continuing pressure from the dammed-up impulses and as a result the phobia spreads. For example, what begins as a phobic reaction to black cats elaborates to include *all* cats and eventually perhaps to all four-legged animals. In various ways the phobic patient finds his "safe" world gradually constricting until he may even be confined to a precarious, miserable existence in one room of his home. Of course the condition may become "stabilized" at any point on the continuum from a barely annoying phobia to virtual imprisonment by fear.

### *Differential diagnosis*

Because of the prognostic importance, two possible diagnostic pitfalls need be mentioned. First of all, a failure to inquire fully into the patient's attitudes about his fears may cause one to mistake a psychotic delusion for a phobia. The phobic patient is fully aware of the illogical and excessive nature of his emotional reaction to the thing feared. In fact, he may become quite depressed and think he is losing his sanity, to have such fears.

Not so the psychotic. A schizophrenic may, for example, mention being afraid of cats; further inquiry may reveal that he fears them because they look at him in a strange way and cause terrible thoughts to come into his mind. Or he may be afraid to go in a certain room because he thinks poison gas is being squirted through the walls. In other words, in view of the psychotic's delusions, his fears are fully justified.

A second possible source of confusion lies in the similarity of some phobias to obsessive thoughts. Indeed, the term phobia is often erroneously applied to certain obsessions, such as the obsessive fear of dying, or an unfounded fear of cancer. It is true that obsessions and phobias may be so intermingled and so closely associated that distinguishing them is difficult. Even the psychiatric textbooks are rather confusing on this point. As a general rule, it might be well to limit the term *phobia* to instances where the anxiety is distinctly referred to something *outside* the patient's own person, avoidance of which serves to ward off anxiety. An obsession is an unwelcome, often painful, idea that intrudes itself into the person's stream of thought, not necessarily related to any outside stimulus. The important practical point is this: treatment is apt to be more difficult, more time-consuming, and less successful when obsessive thinking is a dominant factor.

### *Treatment*

Few psychiatric syndromes offer a clearer indication for psychotherapy than the phobic reactions. Psychoanalysis or psychoanalytically-oriented psychotherapy of the "uncovering" type are generally held to be most effective. In any event, an attempt is made to lead the patient to the unconscious forces motivating his fears and to help him deal with these forces in a mature and healthy manner. This necessarily requires a therapist with specialized psychiatric training.

In situations where the physician without such training must handle the patient, he will do well to avoid any interpretation to the patient of the unconscious conflicts, even when these are obvious. Injudiciously timed interpretations can precipitate panic states in these individuals. A simple, impersonal explanation may be in order, to the effect that a peculiar thing about phobias is that the thing feared often represents something else which the patient is even more afraid to face. The physician might go on to say that the original fear can probably be uncovered if time and a therapist are available, but the patient would likely find the original fear also groundless, having roots in some childhood misconception, emotion-charged, and then forgotten.

Sympathetic listening and assistance in resolving current life problems may be of great help. By merely accepting the patient as an individual and avoiding censure or disparagement, the physician can contribute a great deal toward restoration of the patient's mental health. Some patients derive enough emotional support from this alone to be able to expand their limited range of activities. Sedatives should be given sparingly, if at all, to avoid development of a dependence on them.

It might be mentioned that phobic reactions are the most typical and most common manifestation of anxiety in childhood. Morbid fear of the dark, of the "bogey-man," or of animals are commonly seen. Utilizing the general assumption that a phobic reaction in a child implies some significant emotional insecurity, the physician can sometimes accomplish excellent results by investigating the family situation and working with the parents.

Erickson cites a case of a four-year-old boy who developed a terror reaction at the sight of his grandfather's tractor, even though he had formerly been fascinated by it and had enjoyed riding on it. This happened shortly after the boy's mother had a set of twins. The parents, working on the assumption that the child was feeling relatively neglected and unloved after the twins' arrival, made it a point to give him generous extra attention and affection. Shortly the fear of the tractor disappeared. If all parents were equally alert to the emotional needs of their children, adult phobias might eventually become medical rarities.

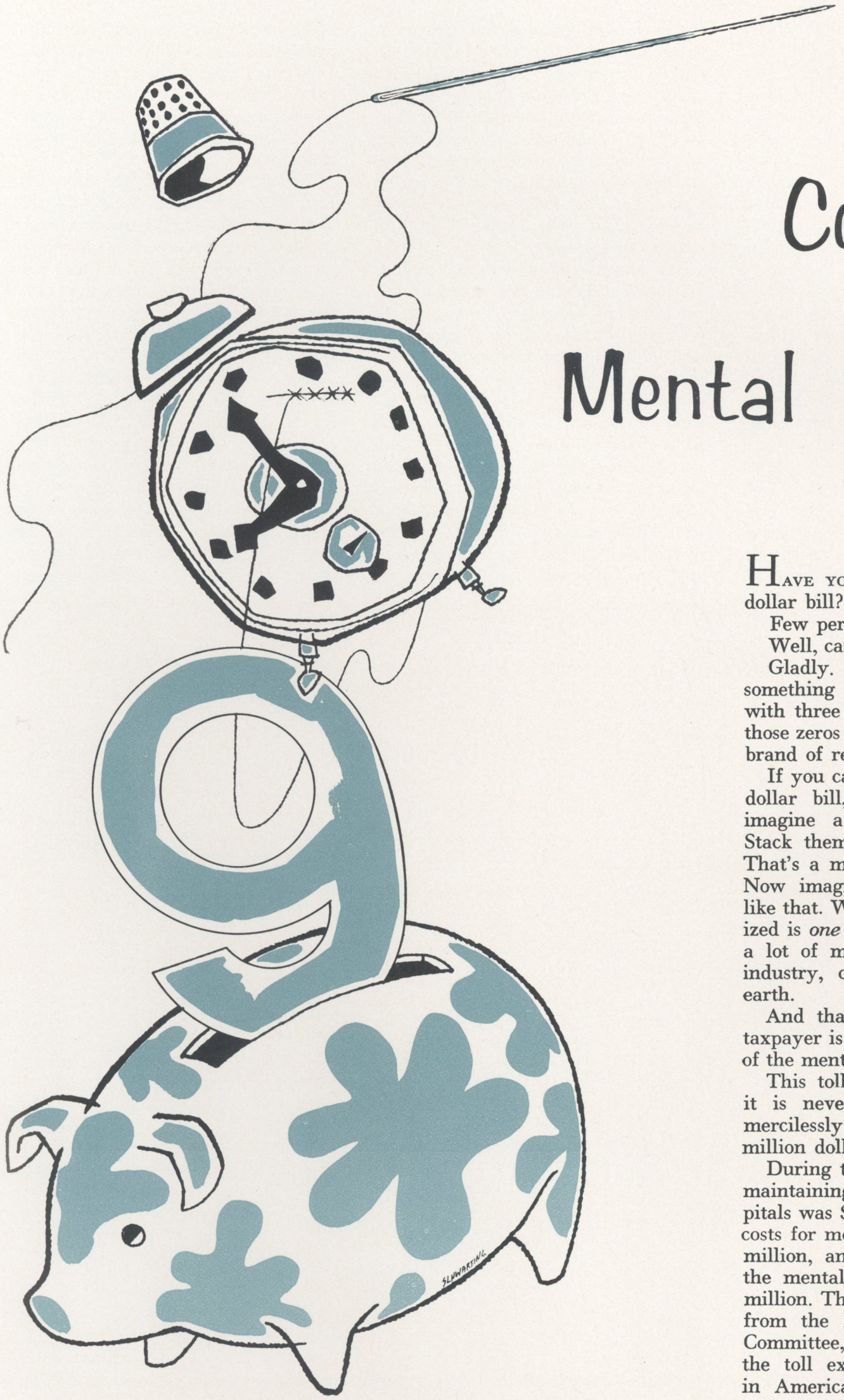
**Suggested Reading**

Fenichel, O.: The Psychoanalytic Theory of Neurosis, New York, W. W. Norton and Co., 1945, p. 193.

Freud, A.: The Ego and the Mechanisms of Defense, London, Hogarth Press, 1937.

Freud, S.: Collected Papers, Vol III, London, Hogarth Press, 1950, p. 149.

Strecker, E. A., et al: Practical Clinical Psychiatry, 7th Ed. Philadelphia, Blakiston Co., 1951, Chap. 11.




# The Cost of Mental Illness

HAVE YOU ever seen a thousand-dollar bill?

Few persons have.

Well, can you imagine one?

Gladly. Imagining is easy. Looks something like a dollar bill, only with three zeros added. But each of those zeros commands its own special brand of respect.

If you can imagine *one* thousand-dollar bill, you can just as well imagine a whole stack of them. Stack them up one thousand deep. That's a million dollars right there. Now imagine one thousand stacks like that. What you have just visualized is *one billion dollars*, and that's a lot of money to anyone, or any industry, or any country, on this earth.

And that is what the American taxpayer is paying annually for care of the mentally ill!

This toll may be staggering, but it is never static. It is climbing mercilessly upward at the rate of 50 million dollars a year.

During the year 1950, the cost of maintaining patients in mental hospitals was $551 million, construction costs for mental hospitals were $186 million, and veterans' pensions for the mentally ill amounted to $360 million. These figures were obtained from the National Mental Health Committee, whose goal is to "reduce the toll exacted by mental illness in America" — through research,

improved facilities, and vitally needed psychiatric training.

Exorbitant as the financial cost may be, it is not so overwhelming as the cost in human suffering which devolves from mental illness.

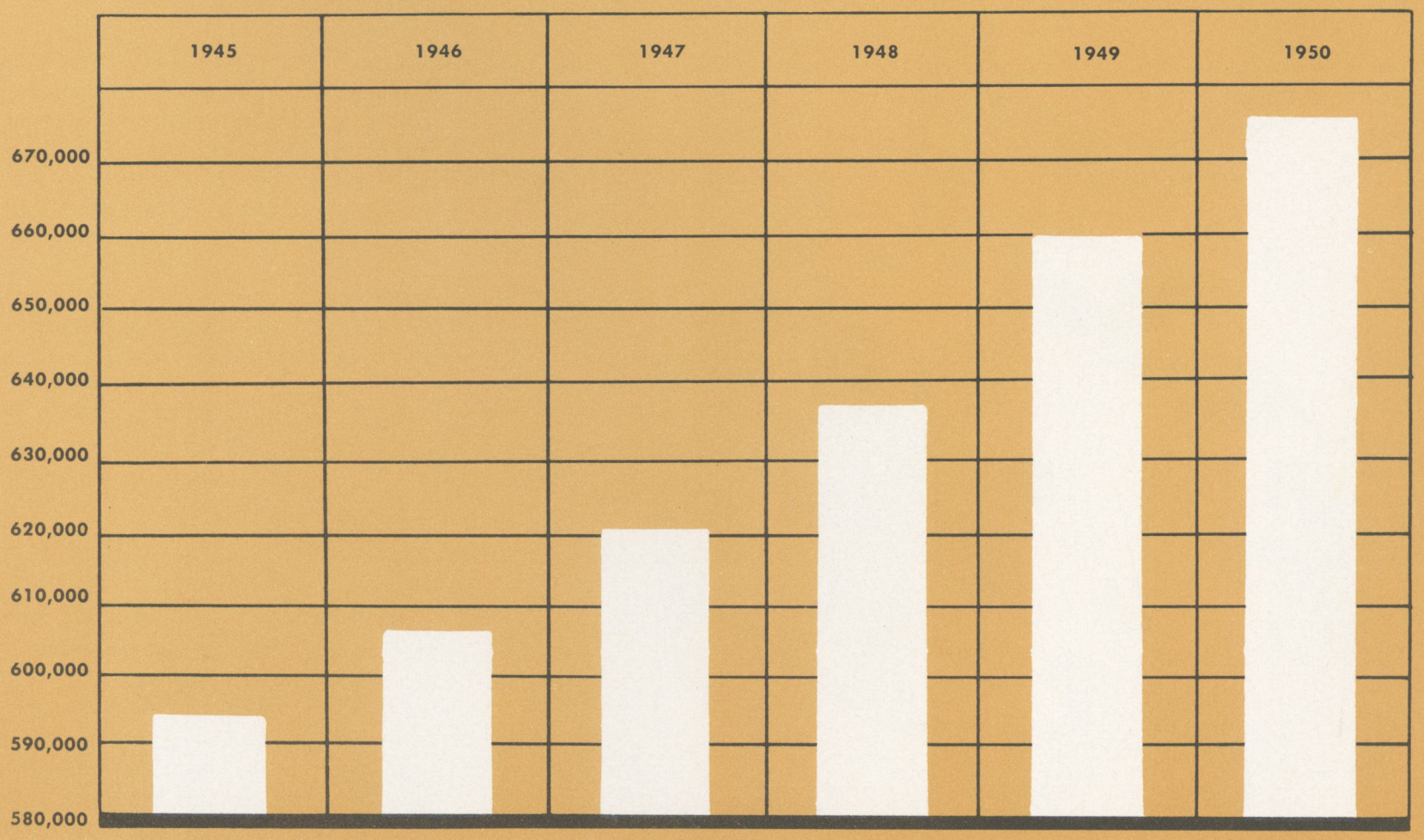
The National Mental Health Committee reports that one in every 18 persons in the United States today is the victim of some form of mental illness. There are over 690,000 patients confined in mental hospitals. At least half of these have schizophrenia. Because of such factors as belated recognition of their condition, inaccessibility of psychiatric personnel, and inadequate hospital facilities, most of these patients cannot be rehabilitated. Yet treatments are known which might have salvaged them, had they been administered early enough. Usually, before the personality undergoes the complete breakdown seen in schizophrenia, there have been a multitude of warning signs. These may be found in the individual's behavior, thinking and emotions. Unfortunately, members of the patient's family lack the distant perspective to note anything peculiar in his isolation, his odd mental associations and his inappropriate emotional reactions. A psychiatrically-oriented physician, however, might readily discern that the patient's hold on reality was precarious.

Army statistics reveal that during World War I, only one-fourth of the psychiatric casualties were able to return to active duty. Psychiatric treatment made tremendous progress within the next 30 years. In the Korean war, psychiatric first-aid became a reality. Emergency stations back of the lines provided immediate psychotherapy within earshot of the big guns up front. In Korea, 70 per cent of the psychiatric casualties were back on active duty within two weeks, and 25 per cent more were able to return within a month or so. Only about five per cent developed mental illness which crystallized to a point at which they had to be invalided home. The knowledge derived from this experience is of historic significance in the field of psychiatric research.

Today, more patients are being admitted to mental hospitals than are being released. If the problem of mental illness is ever to be brought under control, this factor will have to be reversed. Research directed to the prevention of mental collapse can be productive in both dollars and lives.

For the fiscal year ending July 1, 1953, the National Institute of Mental Health had some three million dollars allocated to research. In contrast, the Department of Agriculture spent 40 million dollars in one year on hoof and mouth disease alone. While research directed to prevention is more nebulous than that which eradicates a visible scourge,

**APPROXIMATE NUMBER OF MENTAL PATIENTS IN TAX-SUPPORTED HOSPITALS IN THE UNITED STATES**
**1945 - 1950**



the ultimate benefits of the former may be even more rewarding.

Over the years, research has been responsible for much progress in mental health. Several notable instances are readily recalled. Between 1947 and 1951, new admissions of patients with general paresis in New York were cut in half. This was a by-product of the discovery that penicillin provided a cure for syphilis.

Research in nutrition, with particular emphasis on the Vitamin B Complex, is responsible for the near extinction of psychosis associated with pellagra.

And the current generation of practicing physicians has witnessed the gratifying reversal in the depressive syndromes in patients who have undergone convulsive therapy.

There is yet much more research can do. Indeed, Dr. Stanley Cobb, Chief of the Psychiatric Service, Harvard Medical School, believes that significant practical results toward the cure of schizophrenia could be realized in five years of intensive research, directed particularly to endocrine findings.

In February of 1954, the governors of all 48 states sponsored the National Conference on Mental Health in Detroit, Michigan. One of the major aims of the conference was to find ways of carrying out the proposals made after two years' intensive study by the Council of State Governments throughout the United States. This study, entitled "Training and Research in State Mental Health Programs," comprised 350 pages and was presented at the 45th annual Governors' Conference in Seattle in August, 1953. A summary of the nation's need, as the governors saw it, states:

"Care and treatment alone, along present lines, cannot cope with the present and emerging situations. Hope for the future lies primarily in widening and deepening the knowledge of mental disorder—in the discovery and application of better means of treatment and prevention. These can be attained only through more research, and through training of mental health personnel. Research and training thus are the essential bases for reducing admissions to mental hospitals and, ultimately, for reducing hospital populations."

**Suggested Reading**


National Mental Health Committee fact sheet, What is the Mental Health Situation in the United States today and how does it relate to our National Defense? published in 1953.

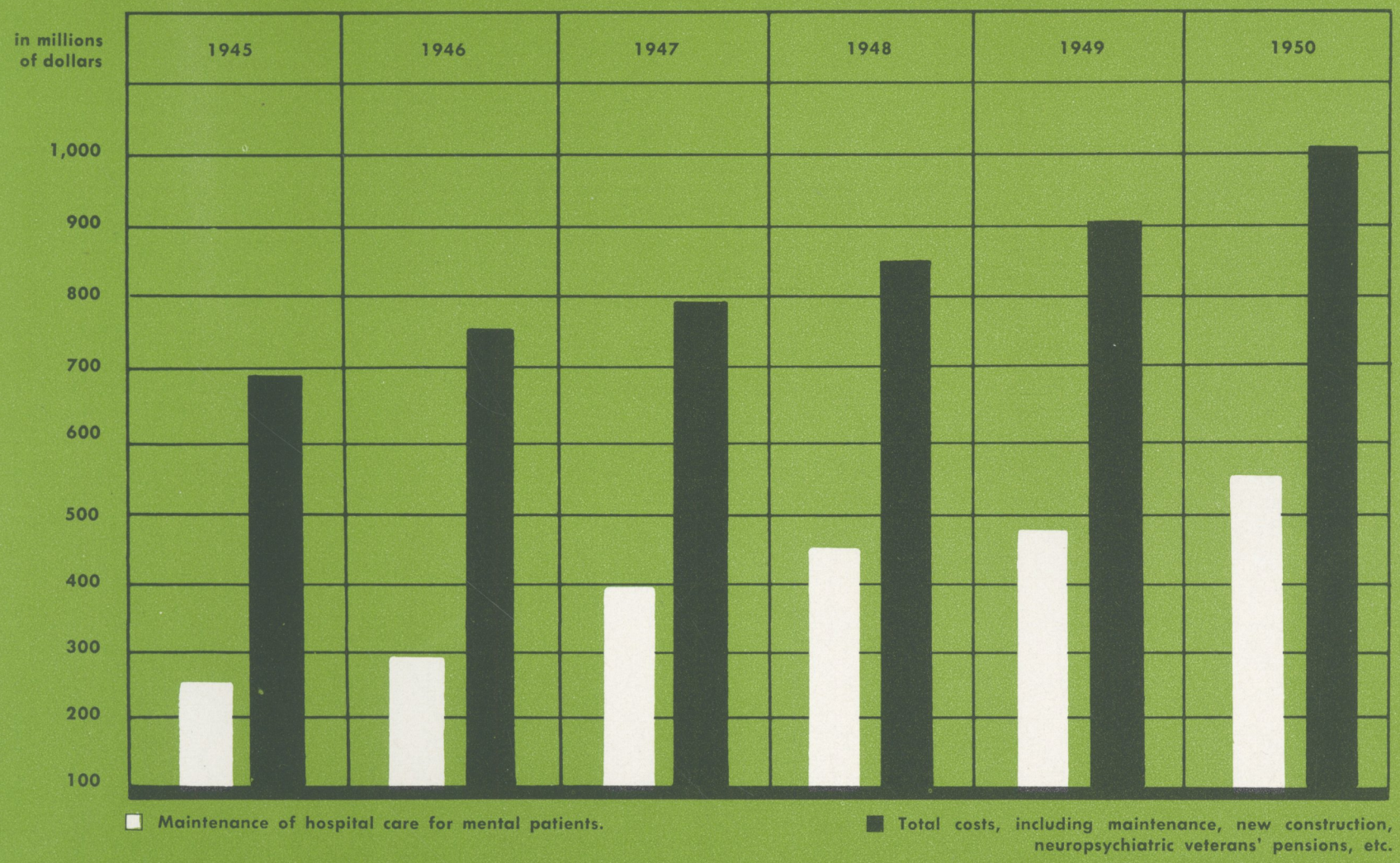
Report of the Governors' Conference by the Council of State Governments; Training and Research in State Mental Health Programs, 1953.

Schlaifer, C.: Mental Health in America at the Crossroads the Last Five Years—the Five Years to Come, Statement before the Subcommittee on Labor, Federal Security Committee on Appropriations, House of Representatives, 1953.

Schlaifer, C.: The Need for an Adequate Mental Health Program, Statement before the Bureau of the Budget, United States Government, May 27, 1952.

Williams, G. M.: The States' Role in the War on Mental Illness, New York Herald Tribune News Service, February 8, 1954.


## ANNUAL TAX BURDEN FOR MENTAL ILLNESS IN THE UNITED STATES
### 1945 - 1950



M.B., a 39-year-old male, was referred for psychiatric consultation with complaints of insomnia, loss of energy, moodiness and irritability. The symptoms had developed gradually over four months and had progressed in severity until he was barely able to continue working and was having occasional spells of crying.

**PHYSICAL STATUS:** Physical examination by the referring physician had revealed no evidence of organic disease. Because of the symptoms of weight loss and diminished appetite, roentgenographic examination of the upper gastrointestinal tract was done; no pathological condition was found. Other laboratory studies included a complete blood count, urinalysis, and a serological test for syphilis, all yielding normal findings.

**PSYCHIATRIC STATUS:** The mental examination revealed profound feelings of despondency and inadequacy, plus suicidal ruminations. The patient felt that he was a failure in his work and a burden to his family. He was anxious, ill at ease, and intermittently tearful during the interview. Productivity of speech was retarded and he complained of difficulty in concentrating. "It feels like a cloud over my mind," he stated. He was extremely concerned over his lack of energy, the loss of weight and appetite, and a recent loss of sexual potency. His orientation was intact, and there were no indications of memory disturbance. Intelligence was estimated to be in the high superior range.

**HISTORY:** The patient was encouraged to give a spontaneous history of the onset of his troubles, and he immediately began to relate it to difficulties connected with his job. A civil engineer, he had been with a large construction company some seven years. About three months before his illness began he had received a sudden and unexpected promotion. In his new position he found himself having to give instructions and orders to several of his former superiors, most of whom were many years his senior. In addition, the work called for greater responsibility in making decisions.

About a month after assuming his new position, he had made an error in judgment on a job which cost the company several hundred dollars. He was quite upset by this but his employer had encouraged him to forget it, saying such things were part of the unavoidable risks of the business. Nevertheless, the incident had become so magnified in the patient's thinking that he was seriously considering making a request to be demoted to his former job. On closer questioning, however, the patient admitted that although this error had been made two months before, *he had not really given the incident much thought until the past three or four weeks.*

Up to this point in the interview the patient had not mentioned his family at all. When asked to tell something of his family, he became visibly upset, his eyes filled with tears, and he was unable to respond for a minute or so. He then spontaneously commented, "Maybe I haven't been telling you the really important things, Doctor." He then related that there were five children, ranging from nine years to eighteen months in age, at approximately two year intervals. Because of religious beliefs, he and his wife practiced no method of contraception, and about six months previously she had become pregnant for the sixth time. They were both upset because of the already difficult financial situation, but they agreed they would manage somehow and said nothing else to one another about the pregnancy being unwelcome. The patient had another reason for his own misgivings; during her two previous pregnancies his wife had been very irritable, continuously ailing, and had required a great deal of extra help from him with both the housework and the care of the children. This he dared not mention to his wife, but he certainly did not relish another hectic nine months of that sort.

In the second month of her pregnancy, the patient's wife had a spontaneous abortion. In telling this the patient commented, "I guess it was right after that when I started getting depressed." By encouraging the patient to elaborate on his emotional reaction to the abortion, he was enabled to verbalize his feelings of relief and secret gratification, feelings which he had hardly dared admit to himself. He felt it was shocking and indecent to have such feelings, and told the psychiatrist "You must think I'm a pretty terrible person." It was immensely relieving to him that the psychiatrist was not shocked and accepted his feelings uncritically.

In subsequent interviews, another important aspect of his emotional reaction came to light. For some time he had been torn between his conscientious religious convictions about birth control and the wish to limit his growing family; the sixth pregnancy made it all too clear that the "rhythm method" was not working for them, and the alternative of abstinence had little appeal. He had tried to put this problem aside after getting over the initial shock of his wife's last pregnancy. But after the miscarriage, the problem could no longer be ignored, since another pregnancy was definitely unwanted. It was obvious that the patient would have welcomed a direct recommendation from the physician which would solve this dilemma and incidentally take part of the responsibility off his own shoulders. He was told, however, that it was *neither the right nor the responsibility of the physician* to make such a decision for him. He was advised that he and his wife would have to face the problem

# Case History no. 1288

squarely themselves and work out a solution they could live with, using religious counsel if desired.

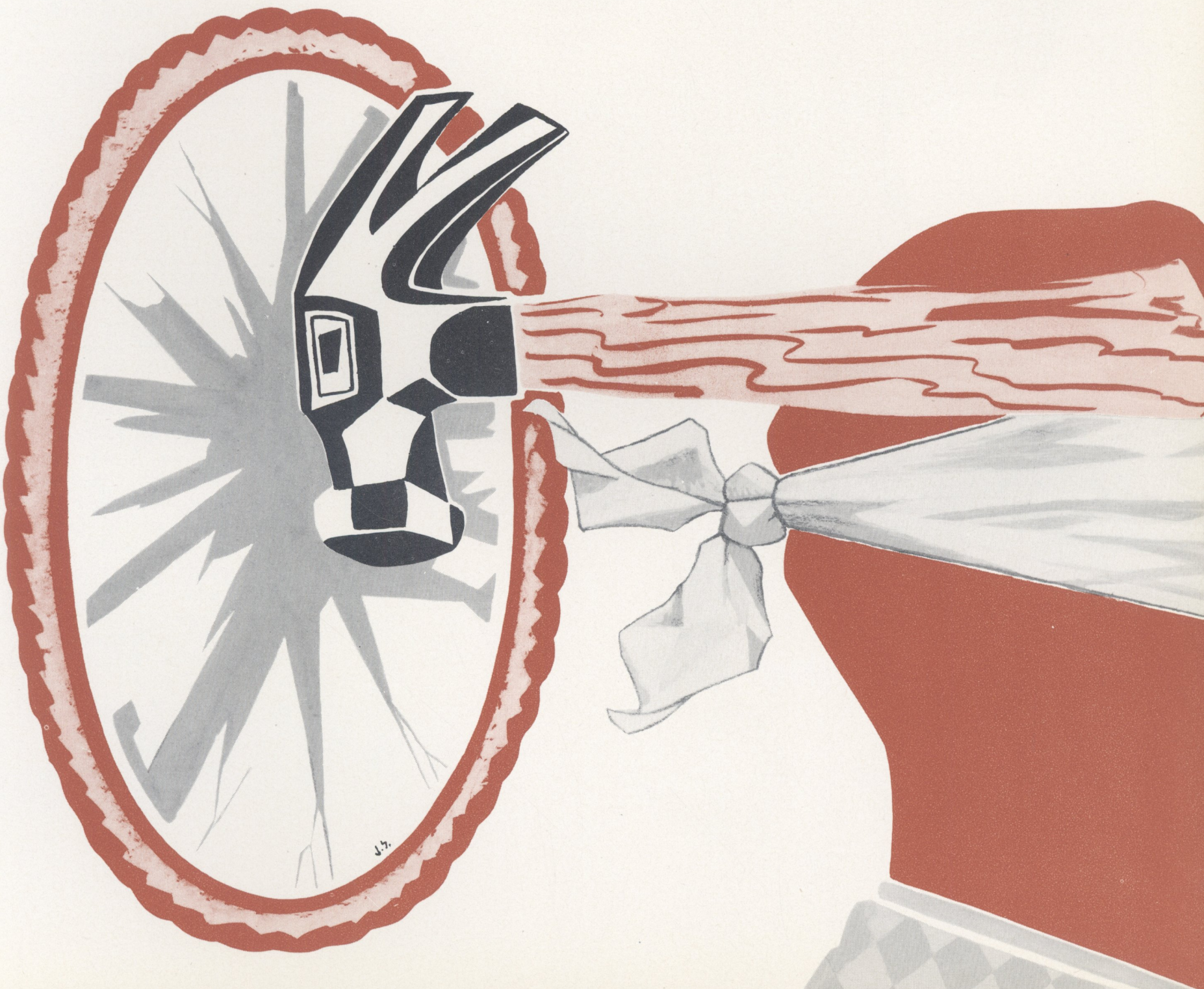
**DIAGNOSIS:** Reactive depression.

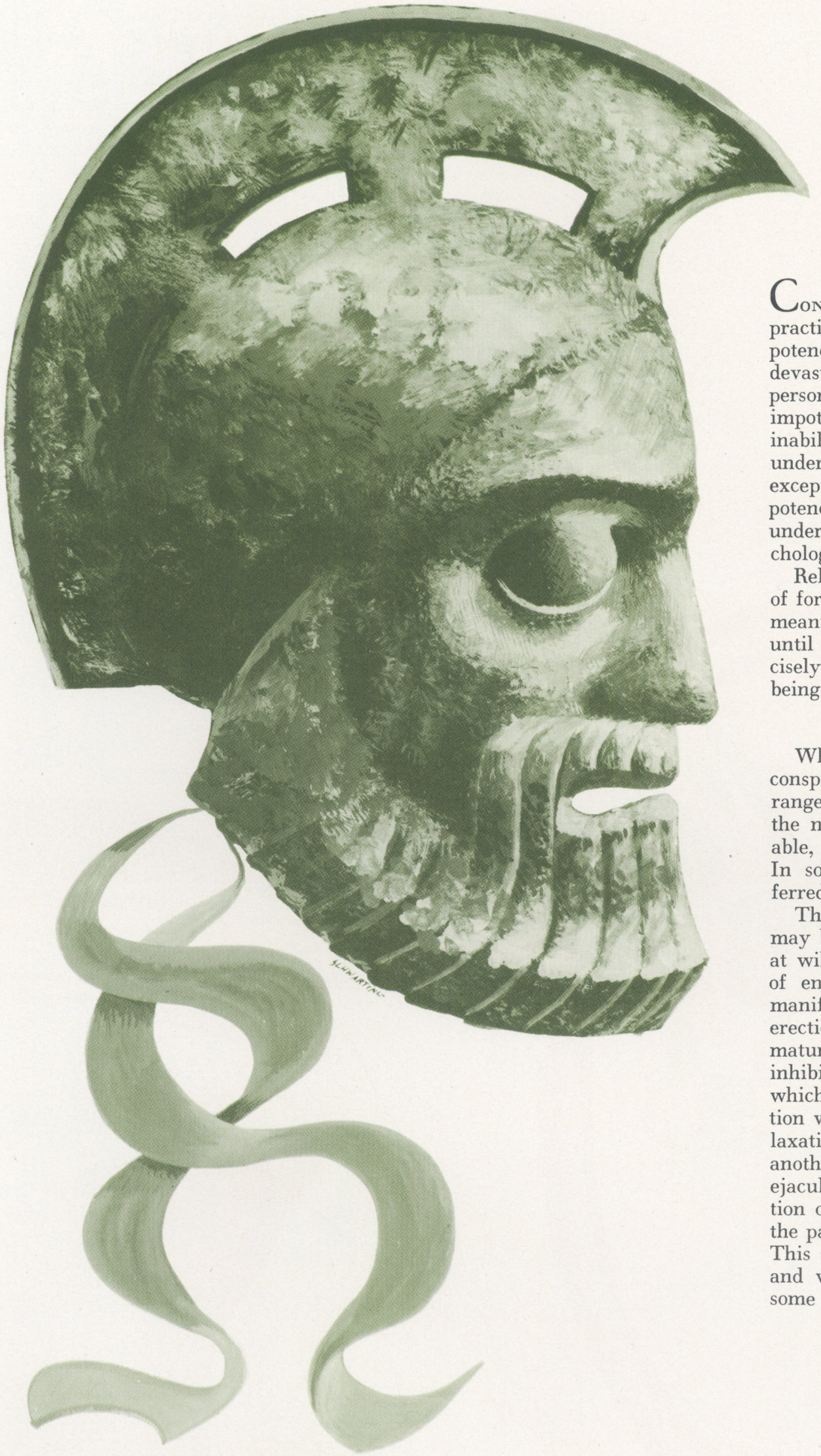
**SUBSEQUENT CLINICAL COURSE:** In the course of six interviews over a two and one-half week period, this man showed a dramatic improvement in symptoms. The sleep disturbance disappeared, appetite returned, and he began to regain interest in his work. At the end of the sixth interview, he asked if he might proceed without the therapist for a while with the option of calling for further appointments if necessary. He was not seen again by the psychiatrist, but a year later his family physician reports he is getting along well and has had no recurrence of symptoms.

**DISCUSSION:** It is obvious that the *precipitating incident* of the abortion would not have produced such an extreme reaction in the average individual. This man was a very meticulous, perfectionistic person who prided himself on his self-control—a sort of unbending, rigid conformist. He habitually insulated himself from any intense emotional relationships. His obsessive character structure had been his principal defense, and when it failed, and he was faced with feelings of not wanting to conform, the depressive reaction resulted.

Therapy was limited to helping him through an emotional crisis precipitated by a difficult life situation, and no basic alteration in personality structure was attempted. Perhaps he will be less vulnerable to a similar reaction in the future as a result of facing and assimilating some emotions within himself that he had previously tried to deny. He learned that "nice" people, and even devoutly religious ones, have "bad" feelings—a valuable object lesson in his case.

This patient, like so many others, had a ready explanation for his feelings of depression which turned out to have little or no relation to the real causes. The need to have things make sense and to justify one's feelings is universal. Consequently, anyone who experiences overwhelming emotions from within has usually hit upon some rationalization for the feelings by the time he reaches a physician. This is also in the service of the unconscious struggle to keep the real feelings hidden, since it directs the attention elsewhere. The physician must therefore avoid taking at face value the patient's explanations for his difficulties. While listening to everything the patient says, it is also vitally important to be alert to *what he does not say*.





# IM

CONSTANTLY appearing in clinical practice is the problem of sexual impotence. This dysfunction can have devastating effects on the patient's personality and family life. Total impotence, consisting of complete inability to obtain a penile erection under any circumstances, is rare except in senility. When erectile impotence occurs consistently in men under 55, the cause is usually psychological.

Relative impotence takes a variety of forms. It is difficult to amass any meaningful statistics on incidence until it has been determined precisely what type of impotence is being discussed.

### *Types of sexual impotence*

When a man's sexual capacity is conspicuously below the average range for his age group, and below the norm which he considers desirable, he may seek medical advice. In some instances, the man is referred for consultation by his wife.

The patient's major limitation may be failure to obtain an erection at will. Or it may lie in the sphere of endurance, in which case it is manifested by inability to maintain erection, resulting in hasty or premature ejaculation. A third type is inhibition of psychic release, in which the man experiences ejaculation with little or no pleasure or relaxation of emotional tension. Still another type is failure to obtain ejaculatory release, in which duration of the sex act is determined by the patient's threshold of exhaustion. This appears to be the rarest of all, and when it occurs, it usually has some physical cause.

# POTENCE

Erectile impotence is the form commonly seen as a presenting complaint. The personal value which a man usually associates with his genital apparatus makes it unlikely that men with ejaculatory or psychic failure will regard themselves as impotent at all. According to Kinsey's statistics, erectile impotence becomes a problem in approximately six per cent of the males under 55, increasing to 25 per cent as the age bracket is extended to 65. As observed in clinical practice, however, the percentages are somewhat higher.

### *Physical aspects of impotence*

Lay publications have done much to promote an oversimplified view of the role of hormones in the body. As a result, it is not surprising that some male patients assume that all their physician has to do is to administer a course of testosterone, following which their impotence will magically cease. They will usually be disheartened to learn that in the absence of endocrine dysfunction, endocrine replacement therapy cannot be expected to produce the desired effects.

Males who, through injury or surgery, have been deprived of their testicles, are suitable candidates for hormonal therapy, unless castration was effected in the hope of arresting cancer of the male reproductive organs. Men whose urinary output of testicular hormones is conspicuously low may also be benefited by androgen therapy, but even in this instance it is a mistake to assume that the amount of steroid present is absolutely correlated with the amount of sexual drive.

Perloff has demonstrated that the specific effects of androgen treatment are local, consisting of increased vascularity, hypertrophy, and sensitivity of the penis in the male and the clitoris in the female, while the administration of estrogens has the reverse effect. Yet neither size nor sensitivity is the major problem in failure to obtain an erection. As Perloff states, "androgens appear to act primarily on the somatic, and only secondarily on the psychic aspect" of sex. Thus, he and other endocrinologists have concluded that the hormonal status does not affect sexual drive in either sex to the extent that psychological factors do.

Among the possible organic causes of impotence are various mechanical anomalies, but these are usually discerned with little difficulty by the physician. Hypertrophy of the prostate may become a problem in older men, and often surgical removal of part of the organ will bring about improvement. Urethral stricture may interfere with penile circulation and so forestall erection. This may be corrected by the urologist. Inflammatory conditions are easily recognized and attacked. Certain diseases of the nervous system may also serve as a basis for impotence, and the symptom will regress upon alleviation of the pathological condition. Bailey, however, states that only two per cent of the patients he has seen who complain of impotence have any organic basis for the symptom. Other

investigators report similar percentages, with the exception of some urologists who see a high percentage of patients referred because of structural defect.

Some physicians have observed that, even in the absence of structural defect, local physical treatment measures involving the male genitalia have been followed by an improvement in sexual potency. However, any physician who treats a preponderance of patients with psychosomatic disorders knows the value of a placebo in patients whose major need is reassurance. The discomfort associated with local therapy may also serve as an atonement in patients whose impotence is closely bound with feelings of guilt concerning sex. The fact that this guilt may be largely unconscious is no detriment to the effectiveness of the therapy. The improvement however, is prone to be short-lived, and impotence will likely recur upon the reappearance of unresolved emotional conflicts.

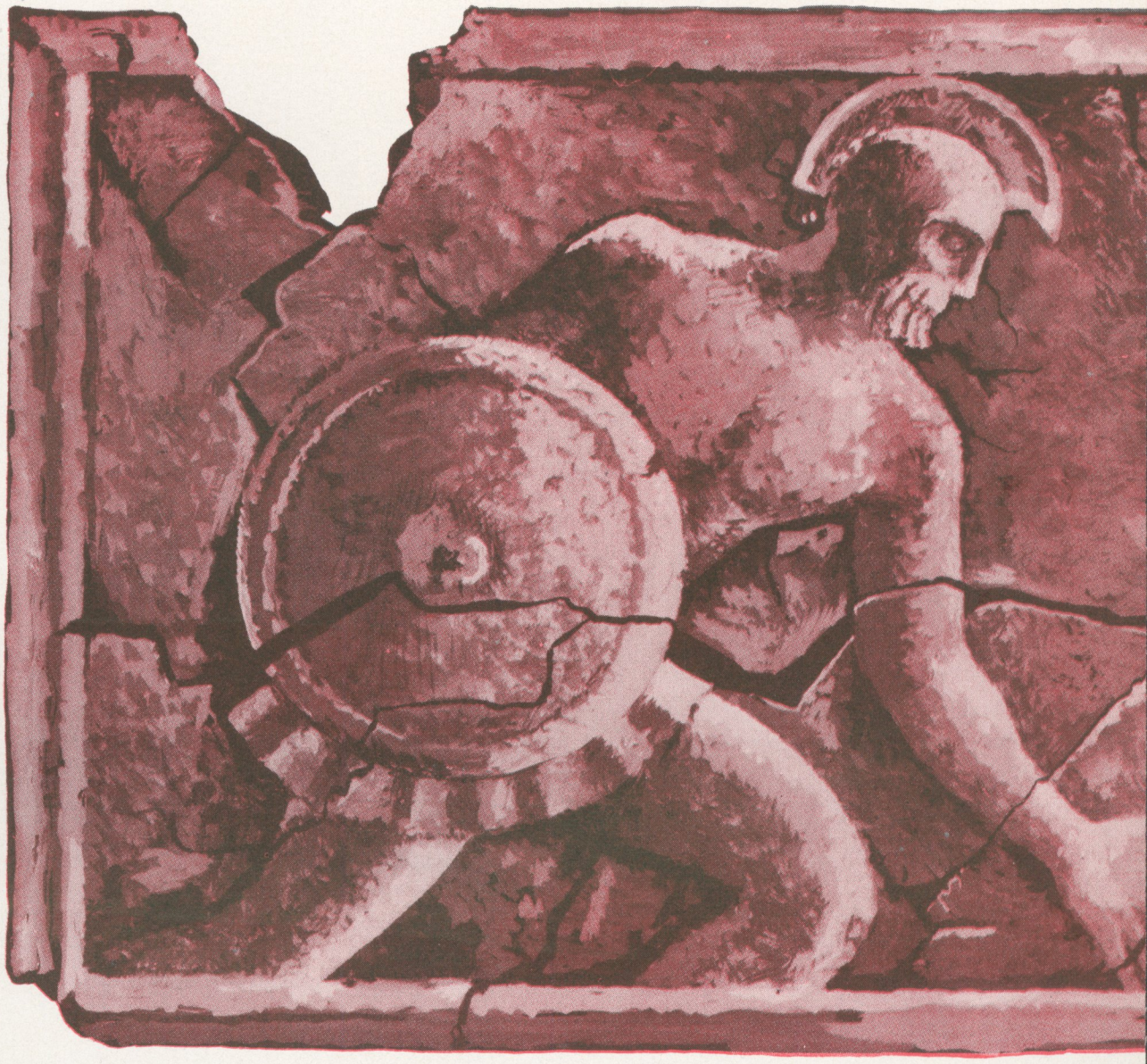
### *Psychological aspects of impotence*

Impotence is most easily corrected when it stems from nothing more serious than faulty education. This is found rather frequently in youthful husbands whose early sexual instruction has been inadequate or downright erroneous. An example of this problem is given in a case history reported by Weiss and English.

### *Impotence as a result of faulty education*

A man of twenty-five, married six weeks, was surprised to find himself impotent with his wife. He had not experienced this difficulty in premarital sexual ventures. When questioned regarding his attitudes toward sex, he stated that he considered his wife "too good for that sort of thing." Further inquiry brought forth the recollection of his mother's instruction: "A woman's body is a sacred temple and should not be defiled." The patient had not applied this attitude to casual extramarital relationships, but he placed his wife in a different category from the other women. His wife's behavior did nothing to dispel this idea, for she, too, was quite inhibited and reserved.

The patient was told that faulty attitudes toward sex which had been instilled in childhood were primarily responsible for his impotence. The cooperation of his wife was enlisted with a suggestion that her aloofness might be modified, to the betterment of the marital relationship. Since the trouble was not deep-seated, only three interviews were required to eradicate the husband's impotence.



While a man is hardly expected to be at his sexual best in a sacred temple, the implication that the sex act defiles the woman is an even more paralyzing thought. One is tempted to wonder what might have been this man's experience had his mother told him instead, "in the act of love, you will bring your wife the best that is in you." This dichotomy in thinking between "sacred and profane" love is far more common than is indicated in clinical records. In many cases it leads to diminished sexual potency with specific partners for which the man himself will have no ready explanation. Often, it is less injurious to his pride to seek another woman than to seek the advice of a physician who could help him.

### *Impotence as a result of mother fixation*

Another variation of the "sacred and profane" attitude toward women is seen in men who are impotent with women who remind them in some way of their mothers. When the sexual partner is selected through need of a mother-substitute, sex takes on an almost incestuous quality. This is below the level of the man's immediate consciousness, however, and is therefore difficult to overcome. Men whose mothers have exerted an unusually dominant influence in their lives often are attracted to women who also dominate them. Unresolved feelings the man held toward his mother are carried over into marriage and applied to his wife. Excessive submissiveness may then prevent the man from developing normal masculine aggressiveness in sex. In some cases of premature ejaculation, psychoanalysis has revealed that unresolved hostility originally felt for the mother has

been directed to the wife, resulting in the unconscious wish to deprive her of sexual satisfaction. Saul reports the case of a young man whose hostility toward women was so intense that he experienced premature ejaculation with women he did not respect, and was totally impotent with those he did.

***Impotence as a result of narcissism***

An immature and self-aggrandizing personality is not conducive to the attainment of maximum sexual potency, though it may be responsible for appalling promiscuity. The typical "Don Juan," whose goal is conquest, is deficient in several qualities essential to a mature sexual relationship. These qualities include protectiveness, tenderness and loyalty toward members of the opposite sex. Many a Lothario would be shocked to learn that his kaleidoscopic romances represent an attempt to ward off latent homosexual inclinations, but psychoanalysts recognize that this is a common manifestation of arrested psychosexual development. In such cases, the entire personality must undergo drastic revision before the individual can achieve genuine sexual maturity.

Bellak reports the case of a forty-five year old man who had formerly worked as a "strong man" in a circus. His potency had proved entirely satisfactory with two previous wives who had been flagrantly unfaithful to him. With his third wife, who was entirely devoted and chaste, he was unable to obtain an erection. To this vain and immature man, sex was primarily a test of phallic competition. Upon the loss of his rivals, the need to compete was gone.

Still another form of narcissism is the adult male's desire to be babied. Mostly this is a normal manifestation, but it can reach pathological degrees. Menninger reports a case in which the husband was potent with his wife until she expressed a desire to have a child. This prospect invoked such panic that impotence resulted. When his feelings were examined, it became apparent that the husband was unwilling to relinquish his position as the "pampered favorite" of his wife, even in behalf of his own child.

***Impotence resulting from fear of punishment***

The various causes which can contribute to the loss of potency in the male are presented separately to avoid undue confusion. Yet in the individual patient, they are usually found in combination. Underlying the entire etiology of psychogenic impotence, fear is perhaps the greatest inhibitor of all.

It is easy to recognize that fear of ridicule or rejection by the woman may impair a man's potency. Fear of contracting venereal disease or of begetting an unwanted child are also easy to relate to impotence. These fears reside close to the surface of the mind, and can be brought to consciousness with little probing.

The neurotic fear is on a deeper level; it is completely unconscious, and difficult to uncover. In impotence it amounts to this: When the need to *avoid* sex is greater than the need to *have* it, the necessary organ will not get ready to perform. The man may be incapacitated and embarrassed. Yet his impotence protects him from what, to him, would be a greater calamity than that.

Laymen and even professional persons unfamiliar with psychiatric findings sometimes scoff at the thought of castration fears, but certain cases of impotence are clearly associated with fear of punishment dating back to early childhood. Hundreds of patients who have undergone psychoanalysis have recalled feelings of intense guilt associated with early sexual curiosity and masturbation. In many instances, the sexual aims of the young child are met with violent punitive measures. Shame and threats are thrust upon the child as soon as he discovers there is pleasure in fondling his genitalia. As he grows older, he is subject to further trauma. The little boy discovers that the little girl has no penis. If no one tells him differently, he may quite naturally assume that the "something terrible" of which he was warned had actually occurred to the little girl. His fear becomes, quite specifically, a dread of penile amputation. Beliefs held

universally by members of the human race are often spotlighted by terms of the vernacular. In this connection, it is of interest to note that in one Swiss dialect, the word for vagina is also translated "scar."

Underlying many forms of impotence, therefore, is basic and irrational fear that sex is wicked, that its indulgence will bring painful retaliation, and that this punishment is a just one and deserved. Intellectually the man knows this is not so, but emotionally, he is back in the cradle, smarting from his initial sex-earned reprimand, or behind the barn, horrified at his discovery of the little neighbor girl's plight. Sometimes these feelings are so deeply buried that it takes many analytic hours to bring them to consciousness.

### *Psychotherapy for the impotent male*

When impotence or premature ejaculation is found in the young bridegroom, the physician can assume that the trouble is probably superficial, resulting from a transient nervousness. Reassurance, the passage of time, and measures directed toward increasing the man's self-confidence are all that are usually required. If faulty education is responsible, and the patient will discuss his attitudes with the physician, these, too, can be corrected with little difficulty. If the impotence persists, and physical examination reveals no organic defect, the trouble is more deeply rooted and more extensive interviewing is in order.

The patient who consults a physician because he is impotent may be reluctant to discuss his condition. Indeed, he may fail entirely to in-include impotence among his presenting complaints. He may complain of insomnia, fatigue, nervousness and vague discomforts and the specific inhibition of sexual activity may not be mentioned until the physician inquires about this phase of life. The patient may then grudgingly admit that his sexual performance leaves much to be desired. This hesitance is in itself a clue to the amount of anxiety the patient harbors. Such a patient may be encouraged to talk freely by suggestions to the effect that disturbance in sexual potency is quite common, but mostly transient, that this is an entirely normal emotional reaction to some unfortunate situation, and that it usually can be corrected when that situation is brought to light.

In accumulating the sexual history, the physician may gain some clue to what sexual intercourse means to this particular man. That is, whether it is an outlet for hostility, or a means of expressing affection; whether it is done in a spirit of conquest, or through a feeling of obligation; whether it leaves the participant feeling fulfilled or with a residue of disgust and shame. The patient may be asked to describe his attitude to the partner or partners he chooses. If the patient is married, the relationship other than sexual between the man and wife is significant. Does he feel patronizing toward her, or does he look on her as though she were his mother? What is his attitude toward the thought of children in the home? How often does he attempt intercourse; does he instigate it, or does his wife? If he is impotent only part of the time, what circumstances prevailed during that particular time? Does he notice any difference in his performance with various women?

By the time the patient answers these questions, both he and the physician will have a better understanding of the problem they are dealing with. In discussing his sexual inhibition, the patient will gradually lose much of the reticence he has felt about sex, and some of the anxiety will be dispelled. The physician can explain that in many cases, misinterpretation of facts can disturb potency, while in other men, early childhood fears have not been entirely dispelled. The interview may be directed to the subject of masturbation, and if the patient overreacts to this, it is an indication that the subject needs thorough clarification.

The physician, by his authoritative position alone, provides an excellent source of reassurance. This, plus his ability to correct misinterpretations regarding sex, is sufficient to dispel most of the psychogenic impotence which is not deep-seated. Even when a severely disturbed personality is involved, considerable improvement in performance may be attained through reassurance, but the realization of maximum sexual potency may be delayed indefinitely.

**Suggested Reading**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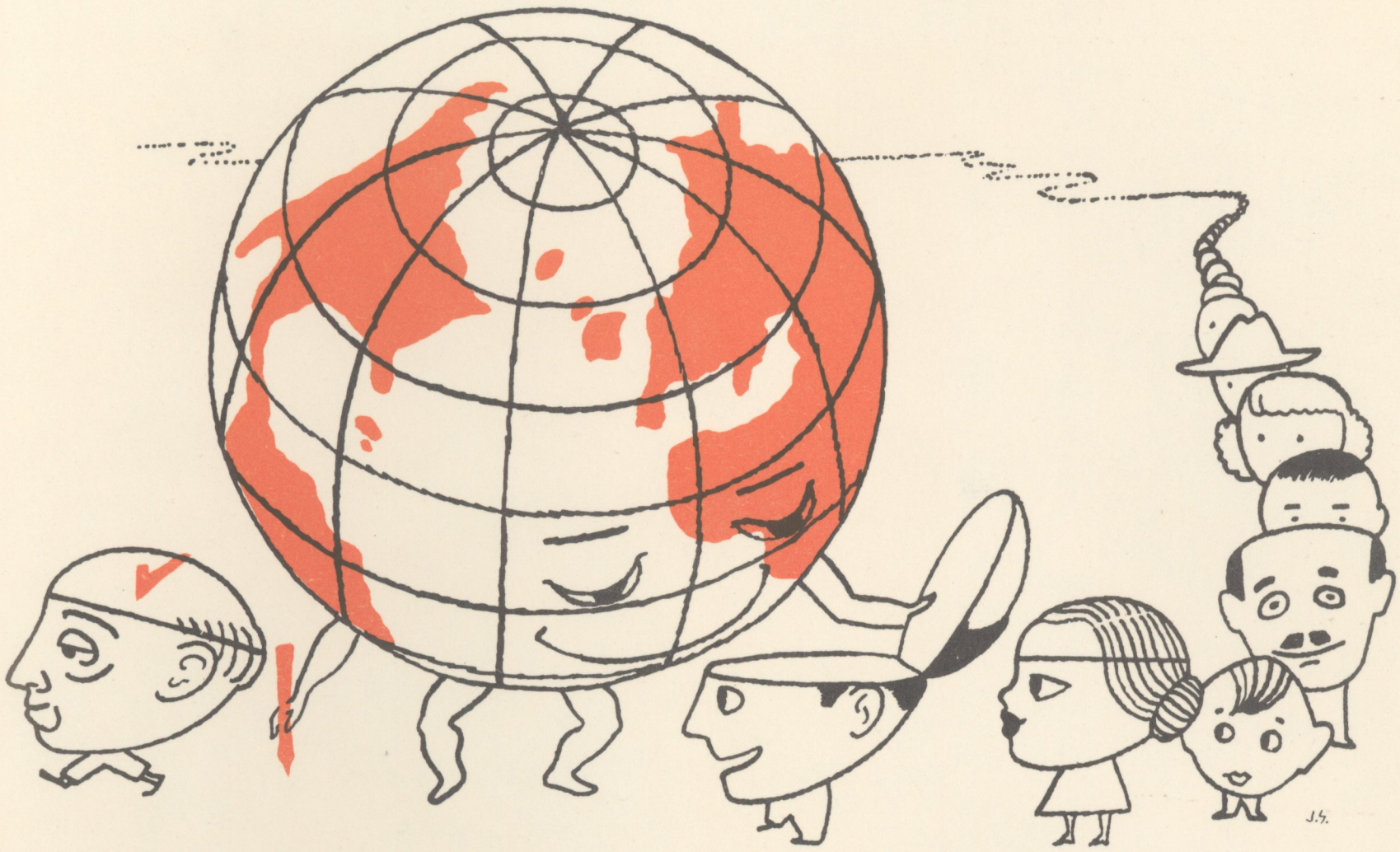

# MENTAL HEALTH:

## *a nation's responsibility*

A CIVILIZATION is only as healthy as the individuals comprising it. This thought was the keynote of Dr. Ewen Cameron's Presidential Address at the 109th annual meeting of the APA. Emphasis was laid on significant factors in the maintenance of mental health and individual responsibility:

"None of us, if we are to be points of security and strength and dependence for our neighbors, can afford to be a man divided against himself. And yet, the fact that we are men and women of our age and, at the same time, men and women deeply engaged in the scientific study of human behavior, renders it perhaps the more difficult for us to maintain that inner consistency which must be the basis of strength."

"THE MENTAL HEALTH of our 160 million people is one of our greatest democratic bulwarks in the struggle for universal peace."

G. MENNEN WILLIAMS
*Governor of Michigan*